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In The
Supreme Court of the United States

ALBERTO R. GONZALES,
Attorney General, *et al.*,

Petitioners,

v.

STATE OF OREGON, *et al.*

Respondents.

On Writ of Certiorari
To The United States Court of Appeals
For the Ninth Circuit

BRIEF OF AUTONOMY, INC. AND CASCADE AIDS PROJECT AS *AMICI CURIAE* SUPPORTING RESPONDENTS

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INTERESTS OF AMICI CURIAE[1]

Amici are organizations which represent people with a wide range of disabilities who share the common belief that individuals with disabilities have the right to make choices and maintain control in all aspects of their lives. They believe that this fundamental right of self-determination applies to all significant life decisions, including what is perhaps the most uniquely personal and intimate decision of all, the decision whether to hasten impending death from a terminal disease when suffering becomes intolerable.

Thus, Amici believe that people with disabilities who are facing imminent death, and who are capable of reasoned and voluntary choice, should be permitted to hasten the end of their suffering with medications prescribed by their physicians and, thereby, to choose a death with dignity. Emphatically, Amici do not believe that responsible legislation providing this choice to terminally ill, competent adults -- including those with disabilities -- in any way poses a threat to them or diminishes their significance as valuable members of society. Accordingly, Amici believe that the people of the State of Oregon have appropriately addressed this issue by enacting the Oregon Death with Dignity Act ("ODWDA" or "the Act"), OR. REV. STAT. §§ 127.800-127.995 (2005).[2]

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[1] Pursuant to this Court's Rule 37.6, no counsel for a party authored this brief in whole or part, and no person other than amici and their counsel has made a monetary contribution for its preparation or submission. Further, the consent of the parties to the filing of this brief has been obtained and filed with the Clerk of the Court.

[2] The Oregon Death with Dignity Act was a citizen's initiative first voted into law by Oregon voters in 1994. Implementation of the Act

Amicus AUTONOMY, Inc. is a national disability rights organization incorporated and headquartered in Oregon. The Board of Directors of AUTONOMY includes some of the most prominent individuals in the disability community, including a young quadriplegic who is a counseling psychologist and editorial journalist, a noted Oregon disability rights activist, an accomplished actor in motion pictures and television who is the Associate Director of the UCLA Center for Neighborhood Knowledge, and a forensic neuropsychologist who conducts research at MIT and is an Associate Professor at the Boston University School of Medicine. All are wheelchair users who have substantial physical disabilities. AUTONOMY's mission is to protect the civil rights of people with disabilities by advocating on behalf of those in the disability community, including those with terminal illnesses, who believe in the principles of choice and self-determination.

Cascade AIDS Project ("CAP") is a non-profit organization headquartered in Oregon. CAP provides support to people who have HIV and AIDS and their families in Oregon and Southwest Washington State. CAP's efforts include educating youths and high-risk adults on HIV prevention and advocating for an effective community

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was delayed by a legal injunction, but after proceedings that included this Court's denial of a petition for certiorari, the Ninth Circuit Court of Appeals lifted the injunction in late October 1997. In November 1997, Oregon voters were asked to repeal the Act, but they declined to do so by a margin of 60% to 40%.

Since 1997, the Act has allowed mentally competent, terminally ill Oregon residents to request and obtain a lethal prescription from their physicians if they are diagnosed to have less than six months left to live. The Act contains numerous safeguards that ensure the Act will be used only for its limited intended purpose, which does not include assisting people with non-terminal conditions.

response to the AIDS epidemic. In 2004 alone, CAP taught 21,523 individuals about HIV prevention and provided direct services to 2,451 people with HIV/AIDS and their affected family members.

Both Amici organizations firmly support the continued implementation of the ODWDA. The interests of Amici reflect the interests of millions of people with disabilities, including people with terminal illnesses, throughout the country. Although the personal circumstances of people with disabilities vary substantially, they share the common interests of being able to live with dignity and to maintain control over their lives. These interests in autonomy and self-determination are the cornerstones of the disability rights movement.[3] Over time, the movement has successfully brought recognition to a broad array of rights for people with disabilities and has established a presumption in our society that disabled individuals should be empowered to make independent decisions about their lives.[4]

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[3] The terms "disability rights movement" and "independent living movement" are often used interchangeably by members of the disability community. Whether they are two separate social movements or two names for the same movement is a matter of debate. For purposes of this brief, the broader term "disability rights movement" is used to refer to both.

[4] *See, e.g., Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 596 (1999) (the right to be free from undue institutionalization and to live in the community); *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982) (the rights to reasonably safe conditions of institutional confinement and to freedom from unreasonable bodily restraints); *In re Marriage of Carney*, 598 P.2d 36, 42 (Cal. 1979) (the right to raise a child); The Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12111-12181 (securing equal opportunities for individuals with disabilities, including the right to have access to public streets, public transportation, schools, public services, privately owned places of public accommodation, and places of

The interests of AUTONOMY and CAP in preserving the rights accorded by the ODWDA are acute. Although most members of the disability community do not have disabilities that are life-threatening in and of themselves, these individuals have the same concerns as anyone else in having the freedom to make all critical life decisions that impact their bodily integrity and dignity, including how to cross the threshold of death should they someday become terminally ill. Moreover, as discussed below, data from Oregon shows that a significant percentage of those invoking the ODWDA's protections are in the death throes of AIDS.

Amici desire a wide range of end-of-life choices should they face a terminal condition, including the right to hasten their own deaths if they determine that life during their remaining few days is no longer bearable and is depriving them of the personhood they have worked so hard to achieve. Further, they want the security of knowing that they can exercise this choice safely, effectively, legally, and in a humane and dignified manner with the professional assistance of their physicians. They reject the paternalistic view that they should be "protected" from their own end-of-life decisions and do not want their disabilities to be cited by others as justification for the wholesale denial of this right to all people with terminal illnesses.

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employment); Individuals with Disabilities Education Act, 20 U.S.C. §1400 et seq. (the right to a free and appropriate education). *See also* Michael Stein, *From Crippled to Disabled: The Legal Empowerment of Americans With Disabilities*, 43 Emory L.J. 25 (1994); Michael Stein, *Mommy Has a Blue Wheelchair: Recognizing the Parental Rights of People With Disabilities*, 60 Brooklyn L. Rev. 1069 (1994); Robert L. Burgdorf, Jr. & Marcia P. Burgdorf, *The Wicked Witch Is Almost Dead:* Buck v. Bell *and the Sterilization of Handicapped Persons*, 50 Temp. L.Q. 995 (1977).

Amici believe that the decision to hasten death is a uniquely personal, moral and religious choice, one that primarily affects the individual involved and his or her loved ones. Most importantly, it is a decision that the people of Oregon have empowered individuals to make for themselves that should not be compromised by undue federal interference.

SUMMARY OF ARGUMENT

The Oregon Death with Dignity Act was approved by the voters of Oregon to permit terminally ill people who are capable of making reasoned and voluntary decisions to end their lives in a humane and dignified manner. The Attorney General impermissibly construed the Controlled Substances Act ("CSA")[5] and its implementing regulations[6] when he issued an interpretive rule criminalizing conduct allowed by the ODWDA.

Amici contend that this decision is properly reserved to the State of Oregon in the exercise of its traditional powers to regulate the medical profession and to define criminal substantive law within its borders, and that these state powers cannot be usurped by administrative fiat. Amici further contend that the ODWDA strikes the appropriate balance between the interests of terminally ill people in the availability of assisted dying as one of several end-of-life choices, and the State's interests in protecting the health and welfare of its citizens. The ODWDA was carefully crafted to guard against potential abuses, coercion and mistake. As a result, in the seven years since the ODWDA's enactment, there has been no evidence of improper application of its

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5 21 U.S.C. §§ 801-971.

6 21 C.F.R. § 1306.04, et seq.

provisions, nor of a discriminatory effect on individuals with disabilities. Moreover, the physician's role in assisted dying under the ODWDA comports with the many and complex ethical obligations that physicians have towards their patients. As indicated by this Court and the American Medical Association, these traditional obligations include the physician's duties to respect patient autonomy, to provide comfort, to alleviate pain and suffering, and to not abandon his or her patient once it becomes apparent that the patient is terminally ill.

ARGUMENT

Oregon's Death with Dignity Act strikes a legitimate balance between the interest of terminally ill people in having the option of assisted dying and the State's interest in protecting the health and welfare of its citizens.

The ODWDA carefully balances the interest of terminally ill individuals to exercise autonomy over the most critical end-of-life decisions with the State's legitimate concerns in protecting the health and welfare of its populace. In its right-to-die cases that preceded the ODWDA, this Court identified several legitimate state interests that justify careful regulation of the decision of a mentally competent, terminally ill patient to seek a physician's aid in dying. *See Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997). In the companion cases *Glucksberg* and *Vacco*, this Court declined to recognize a fundamental, generalized right to commit suicide and upheld the constitutionality of two state laws prohibiting physician-assisted suicide after determining that the statutes at issue reasonably served legitimate state interests. *Glucksberg*, 521 U.S. at 734-35; *Vacco*, 521 U.S. at 808-09. This Court

observed that these state interests include: (1) protecting terminally ill people, including those in otherwise vulnerable groups, from abuses, coercion and "societal indifference;" (2) preventing suicide; (3) avoiding a possible slide from physician-assisted suicide to voluntary or involuntary euthanasia; and (4) protecting the ethics and integrity of the medical profession. *Glucksberg*, 521 U.S. at 728-35; *Vacco*, 521 U.S. at 808-09.

At the time *Glucksberg* and *Vacco* were decided, no U.S. jurisdiction had implemented a statute authorizing physician-assisted dying, and this Court expressed concern about the absence of empirical data to show that state regulation could adequately safeguard these state interests. *See Glucksberg*, 521 U.S. at 735; *see also id.* at 785-86 (Souter, J., concurring). This Court emphasized, however, that states are positioned ideally to grapple with nascent issues such as assisted dying and anticipated that states would do so, serving as laboratories entrusted with the challenging task of crafting appropriate protections. *See Glucksberg*, 521 U.S. at 735; *see also id.* at 737 (O'Connor, J., concurring). Since the implementation of the ODWDA in November 1997, Oregon has served as such a laboratory. Documentation of the Oregon experience shows that "the provisions of the statute have been implemented consistently 'with the predictions of its proponents and with no evidence of abuses foreshadowed in the slippery-slope characterizations of its opponents.'" Bryan Hilliard, *Evaluating the Dissent in* Oregon v. Ashcroft: *Implications for the Patient-Physician Relationship and the Democratic Process*, 33 J. L. Med. & Ethics 142, 147 (2005) (quoting B.A. Rich, Oregon v. Ashcroft: *The Battle Over the Soul of Medicine*, 12 Cambridge Quarterly of Health Care Ethics 313 (2003)).

I. Oregon acted within its authority in passing the ODWDA, and its policy choice should be respected.

Amici recognize that throughout this country, "Americans are engaged in an earnest and profound debate" concerning "the morality, legality, and practicality" of physician-assisted dying. *Glucksberg*, 521 U.S. at 735. A virtue of our federalist system, however, is that it fosters innovation by allowing for the possibility that "a single courageous State may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments without risk to the rest of the country." *Reeves, Inc. v. Stake*, 447 U.S. 429, 441 (1980) (quoting *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)); *see also Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring). Oregon's implementation of the ODWDA typifies the role of States as laboratories.

This Court has long recognized that States' core police powers include the authority to regulate the medical profession and to define criminal substantive law within their borders. *See, e.g., Whalen v. Roe*, 429 U.S. 589, 603 n. 30 (1977) ("It is, of course, well settled that the State has broad police powers in regulating the administration of drugs by the health professions" (citing *Robinson v. California*, 370 U.S. 660, 664-65 (1962); *Barsky v. Bd. of Regents*, 347 U.S. 442, 449 (1954); *Minnesota ex rel. Whipple v. Martinson*, 256 U.S. 41, 45 (1921)); *Hillsborough Cty v. Automated Medical Laboratories*, 471 U.S. 707, 715-16 (1985) (recognizing States' historic police powers to regulate health and safety and stating that these powers are presumed not to be superseded by a federal agency's health regulation promulgated "pursuant to a congressional delegation" "unless that was the clear and manifest purpose of

Congress"); *Brecht v. Abrahamson*, 507 U.S. 619, 635 (1993) (recognizing that under our principles of "comity and Federalism[,]" "[t]he States possess primary authority for defining and enforcing the criminal law"); *United States v. Bass*, 404 U.S. 336, 349-50 (1971) (same, noting further that "unless Congress conveys its purpose clearly, it will not be deemed to have significantly changed the federal-state balance").

Exercising this authority, Oregon has decided (by legislative codification of a voter initiative) that a mentally competent, terminally ill individual should have the freedom of choosing to hasten an end to his or her suffering with a physician's assistance, and that the individual's interest in having this option outweighs any countervailing state interests. *See* OR. REV. STAT. § 127.805. The ODWDA also reflects a policy determination that assisted dying has a medical purpose worthy of an exemption from criminal liability for physicians who comply with the Act. *See* OR. REV. STAT. § 127.885.

This difficult and sensitive policy choice is the culmination of a democratic process that considered input from Oregon's medical community, disability community, family members of terminally ill people, and bioethicists.[7] Regardless of whether one agrees with the Attorney General's view of how Oregon has chosen to regulate its

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[7] *See, e.g., Hearing before the Oregon Senate Committee on HB 2954* (May 27, 1997) (Death with Dignity Act); *Hearing before the Oregon House Committee on Judiciary Subcommittee on Family Law on HB 2954* (April 23, 1997) (same); *Hearing before the Oregon House Committee on Judiciary Subcommittee on Family Law on Measure 16* (January 29, 1997) (voter initiative approving Death with Dignity Act); *see also Hearing before the Oregon Senate Committee on Judiciary on SB 491* (March 17, 1999); *Hearing Before the Oregon Senate Committee on Health Insurance and Bioethics on SB 1141* (April 30, 1991).

medical profession and to protect physicians from criminal liability, the CSA does not authorize him to unilaterally override by administrative fiat one state's considered policy choice.

II. Seven years' data shows that the Oregon Death with Dignity Act protects the State's legitimate interests and poses no threat to public health or welfare.

The ODWDA contains detailed reporting and monitoring requirements[8] that have generated a sizeable amount of data on the circumstances and demographic characteristics of terminally ill individuals who have sought their physicians' aid in dying under the Act. This data demonstrates that there is no evidence that the statute has been used inappropriately or has resulted in any discrimination against or abuse of terminally ill individuals, including those who are members of the disability community. Indeed, conspicuously absent from Petitioners' brief is any example of an instance in which any of the dangers feared by the statute's opponents has materialized in the seven years since its inception. In particular, Petitioners assert, without further elaboration, that legalized physician-assisted dying "would pose profound risks to many

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8 The ODWDA requires that Oregon's Department of Human Services ("DHS") collect and maintain information on hastened dying under the Act. OR. REV. STAT. § 127.865. Physicians must timely notify the DHS of any lethal prescription written and document their compliance with the law. OR. REV. STAT. §§ 127.815, 127.855. The DHS, in turn, must assess the information collected and release a statistical report annually. OR. REV. STAT. § 127.865. In recent years, including 2005, the DHS has also conducted telephone interviews with all of the prescribing physicians. *See* Oregon Dep't of Human Servs., *Seventh Annual Report on Oregon's Death with Dignity Act* 10 (2005) ("Seventh Annual Report on the ODWDA").

individuals who are ill and vulnerable," Petitioners' Brief at 23, and that this end-of-life option is "fundamentally incompatible with the physician's role as healer." *Id.* at 8. Yet Petitioners do not and cannot point to any danger with specificity that could not be readily refuted by the actual experience of the State of Oregon since the implementation of the ODWDA. In particular, Oregon's experience shows that the ODWDA effectively protects each of the four state interests identified by this Court in *Glucksberg* and *Vacco*.

A. The ODWDA protects all terminally ill people, including those in vulnerable groups, from abuse, coercion and "societal indifference."

Petitioners' argument that assisted dying under the ODWDA "poses a threat to individuals who are ill and vulnerable" erroneously assumes that members of these groups are not capable of making a rational and voluntary decision to hasten their imminent and inevitable deaths. This paternalistic view is anathema to Amici and numerous members of the disability community and threatens to set back decades of legislative action and social advocacy devoted to the goal of empowering the disabled to take control over every aspect of their lives.

Moreover, the ODWDA contains numerous safeguards to ensure that a terminally ill individual's choice to hasten death with a physician's assistance is made voluntarily and free of coercion or undue influence from outside forces. The danger posed by coercion and societal indifference is that the patient will be pressured to choose a path that he or she otherwise would not choose. Opponents to assisted dying seek to do just that by substituting their own moral, philosophical or religious views for that of all patients through the elimination of this end-of-life choice.

See, e.g., Amici Brief of Not Dead Yet, et al., 1-2. The ODWDA, however, protects the decision-making autonomy of the patient by insulating him or her from these coercive forces and giving effect to the patient's true wishes, whatever course he or she chooses.

At the core of the ODWDA is the requirement that the decision to hasten death be made capably, voluntarily, and with full information. Thus the ODWDA explicitly applies only to "capable"[9] adult Oregon residents who have been diagnosed by the attending physician to be suffering from a terminal disease likely to result in death within six months, OR. REV. STAT. § 127.805, and requires two oral and one written request from the patient, OR. REV. STAT. § 127.840, the latter to be witnessed by two individuals who must attest that the patient is "capable, acting voluntarily and is not being coerced to sign the request." OR. REV. STAT. § 127.820. At least one of these witnesses cannot be a relative of the dying individual or have a stake in his or her estate. OR. REV. STAT. § 127.810 s 3.02 (2)(a)-(b). The ODWDA also requires that the physician inform the patient of the feasible alternatives to assisted dying, including "comfort care, hospice care and pain control," OR. REV. STAT. § 127.815 s 3.01 (1)(c)(E); requires that the patient be referred to a consulting physician for confirmation of the diagnosis and a determination that the patient is capable and acting voluntarily, OR. REV. STAT. § 127.815 s 3.01 (1)(d); imposes a fifteen-day waiting period between the patient's initial

[9] Under the ODWDA, "capable" "means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available." OR. REV. STAT. § 127.800 s 1.01 (3).

request and the writing of the prescription; OR. REV. STAT. § 127.850; and permits the patient to rescind the request at any time. OR. REV. STAT. § 127.845. If either the attending or consulting physician has any concern that the patient's capacity to make the decision is impaired by a psychological or psychiatric disorder or depression, the ODWDA explicitly requires that a licensed psychologist or psychiatrist be consulted, OR. REV. STAT. § 127.825, and prohibits any medication from being prescribed until a determination regarding the presence or absence of impaired judgment is made. OR. REV. STAT. § 127.805. Finally, the statute specifically provides that "[n]o person shall qualify solely because of age or disability," OR. REV. STAT. § 127.805, and makes it a felony to coerce a patient to request medication to hasten death or to conceal or destroy a rescission of such a request. OR. REV. STAT. § 127.890.

That these safeguards meaningfully function is evidenced by data documenting Oregon's experience with the ODWDA, which shows that physicians are performing capacity assessments as required by the Act and that not all patients' requests for medication are granted.[10] *See* Oregon Dep't of Human Servs., *Seventh Annual Report on Oregon's Death with Dignity Act* 12 (2005) (*"Seventh Annual Report on the ODWDA"*); Linda Ganzini, et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 New Eng. J. Med. 557, 559-60 (2000) (*"Physicians' Experiences with the ODWDA"*). Further, studies have confirmed that physicians are making ineligibility determinations based on whether a patient's judgment is

[10] One survey of Oregon physicians found that only 18% of patients who requested assisted dying under the ODWDA ultimately received a prescription. Linda Ganzini et al., *Physicians' Experiences with the Oregon Death with Dignity Act*, 342 New Eng. J. Med. 557, 598-60 (2000).

impaired, and are not simply doling out prescriptions to anyone who asks for one. *See, e.g., Physicians' Experiences with the ODWDA,* 342 New Eng. J. Med. at 559-60. In one study surveying Oregon physicians, responses indicated that 17% of the individuals seeking medication to hasten death had "a mental disorder such as depression which impaired his/her judgment," and that none of these patients received prescriptions under the ODWDA. *Id.* The authors of that study concluded that the data did not "support the hypothesis that among patients eligible for assistance with suicide under the [ODWDA], vulnerable groups, including mentally ill patients, request suicide disproportionately or receive lethal prescriptions in place of palliative care." Linda Ganzini, et. al., *Letter to the Editor*, 343 New Eng. J. Med. 152, 152 (July 13, 2000).

Although some members of the disability community assert that people with disabilities are more vulnerable than others when assisted suicide is authorized by statute, data on the application of the ODWDA shows that this concern is unfounded. In the Oregon Department of Health's most recent study and report, the DHS observed that the demographics of patients who sought assisted dying under the ODWDA did not support opponents' fears of coercion or discrimination. *See Seventh Annual Report on the ODWDA* at 15. The study found that those requesting this end-of-life option tended to have a higher level of education than others who were terminally ill; Oregonians holding a bachelor's degree were 8.3 times as likely to request assisted dying. *Id.* at 13. The particular illness suffered was also a strong predictor of utilization of the Act; the illnesses most commonly afflicting those seeking assisted suicide were Amyotrophic Lateral Sclerosis (ALS, or Lou Gehrig's Disease), HIV/AIDS, and malignant neoplasms. *Id.* at 13. Moreover, neither depression nor uncontrollable pain were strong predictors of the likelihood that a terminally ill

individual would seek physician-assisted dying. Rather, the most common reasons terminally ill patients give for choosing this end-of-life option are loss of autonomy, a decreasing ability to participate in activities that make life enjoyable, and loss of dignity. *Seventh Annual Report on the ODWDA* at 15.

B. The ODWDA does not foster suicide generally, or among the disabled.

Some disability organizations assert that Oregon's legalization of physician-assisted dying will have the cumulative impact of devaluing the lives of people with disabilities. *Amici* Brief of Not Dead Yet, et al., at 19. Implicit in this argument is the assertion that by delineating some conditions as qualifying individuals for the option of assisted suicide, the State implies that those in the eligible categories have a lower quality of life than others and that they are less valuable members of society.

The ODWDA's distinction, however, between individuals with terminal conditions and those without does not manifest the State's judgment as to the relative value or quality of life of any individual. Quality of life is a subjective valuation that belongs to the individual, not to anyone else. Under the ODWDA, only the individual facing imminent death can decide whether his or her quality of life justifies enduring whatever emotional or physical pain and suffering he or she is experiencing. By permitting that individual "to make [a] judgment about the quality of life that [he or she] may enjoy," the ODWDA "gives proper recognition to the individual's interest in choosing a final chapter that accords with [his or] her life story, rather than one that demeans [his or] her values and poisons memories of [that person]." *See Glucksberg*, 521 U.S. at 746-47 (citing and quoting *Glucksberg*, No. 96-110, *Amici* Br. of

Bioethicists at 11; RONALD M. DWORKIN, LIFE'S DOMINION 213 (1993)) (Stevens, J., concurring) (internal quotation marks and citations omitted). Whether it is in the terminally ill individual's "best interests" to choose one manner of dying rather than another depends on so much that is unique to that individual --"'the shape and character of his life[,] his own sense of his integrity and critical interests--that no uniform collective decision can possibly hope to serve everyone even decently.'" *Id.* at 747 (quoting RONALD M. DWORKIN, LIFE'S DOMINION 213 (1993)) (Stevens, J., concurring). For these reasons, the ODWDA recognizes that this critical end-of-life choice belongs to the individual alone. Neither the State nor the health care providers may decide, based on their conceptions of the individual's quality of life, whether assisted suicide is appropriate in a given case.

Nor does Oregon's implementation of the ODWDA foster suicide generally. Suicide represents in its most basic terms a choice between life and death, and is commonly perceived as a self-destructive act motivated by mental impairment -- a condition for which treatment might avoid death. In the case of a terminally ill individual, however, death is already his or her imminent fate; that individual is "faced not with the choice of whether to live, only of how to die." *Glucksberg*, 521 U.S. at 746 (Stevens, J., concurring). Terminally ill patients who choose to hasten their deaths seek to avoid a prolonged and dehumanizing process of dying. Such an individual seeks to hasten death because, in his or her view, "the quality of life during the time remaining . . . ha[s] been terribly diminished," his or her life "has been physically destroyed and its quality, dignity and purpose gone." *Bouvia v. Superior Court,* 225 Cal. Rptr. 297, 304-05 (Cal. Ct. App. 1986) (describing patient's reasons for requesting withdrawal of life support to hasten death). Under these circumstances, the choice to hasten death is more akin to the decision to refuse life-sustaining measures -- a

decision that is ethically and legally condoned -- than what is commonly perceived as "suicide."

While a terminally ill person might also suffer from depression or other mental disorder, as noted above, the ODWDA's requirements to ensure the capability of the patient requesting a lethal dosage screen out individuals who suffer from impaired judgment. The efficacy of the ODWDA's safeguards is evident in data from mental health studies which confirm that terminally ill individuals seeking assisted dying are capable of making major health care decisions and that those who receive prescriptions for lethal doses do not suffer from impaired judgment or clinical depression. *Physicians' Experiences with the ODWDA*, 342 New Eng. J. Med. at 562-63 .

Moreover, to the extent that a terminally ill individual who seeks to utilize the Act does suffer from mental incapacity or unbearable pain, the request for assisted suicide triggers intervention by the health care provider, who must assess the patient's capacity, inform him or her of alternative treatments, including palliative care, and may explore a patient's concerns and desires about end-of-life care. *See Seventh Annual Report on the ODWDA* at 17 (noting that "[o]ften once the patient's concerns have been addressed by the provider, he or she may choose not to pursue [physician-assisted suicide]" (citing Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since the Passage of the Death with Dignity Act*, 285 JAMA 2363, 2363-69 (2001)). Indeed, the notion that legalized assisted dying and the development of excellent palliative care are mutually exclusive has been largely debunked by seven years' data from Oregon on the application of the ODWDA. *See* Timothy E. Quill, *Dying and Decision-Making – Evolution of End of Life Options*, 350 New Eng. J. Med. 2029, 2030 (2004) (*"Evolution of End*

of Life Options"). In Oregon, only a small percentage of all deaths may be attributed to assisted dying under the statute (approximately 0.1 percent across seven years), *Seventh Annual Report on the ODWDA* at 16; of those who have relied upon the Act, more than three-fourths were concurrently enrolled in hospice programs. *Evolution of End of Life Options*, 350 New Eng. J. Med. at 2030; *Seventh Annual Report on the ODWDA* at 14. During 2004, all patients but one died at home; 89% were enrolled in hospice care. *Seventh Annual Report on the ODWDA* at 14.

The legalization of assisted dying in Oregon may also have encouraged doctors "to address other end-of-life care options more effectively." *Id.* In one study of Oregon physicians, the physicians reported that since the initial passage of the ODWDA in 1994, they had taken steps to increase their knowledge of palliative care for the terminally ill, to improve their ability to identify mental impairments such as depression, and to refer more patients to hospice care. *Seventh Annual Report on the ODWDA* at 17 (citing Linda Ganzini et al., *Oregon Physicians' Attitudes About and Experiences with End-of-Life Care Since the Passage of the Death with Dignity Act*, 285 JAMA 2363, 2363-69 (2001)).

C. *The ODWDA imposes strict limitations on the circumstances under which assisted dying is authorized and precludes a slide towards euthanasia.*

Opponents to physician-assisted dying point to the Netherlands as proof that the practice cannot be limited to people with terminal illnesses and that legalization of assisted dying will lead to voluntary or involuntary euthanasia. The Netherlands example, however, merely underscores the need for state regulation of assisted dying such as that afforded by the ODWDA.

Until recently, both physician-assisted suicide and euthanasia were illegal under the Dutch Criminal Code, but conditionally legalized by the Dutch Courts, which developed guidelines delineating the circumstances under which a physician would be exempt through a defense of "necessity" from criminal liability for participating in either practice. Roger S. Magnusson, *"Underground Euthanasia" and the Harm Minimization Debate*, 32 J. L. Med. & Ethics 486, 490 (2004) (*"Underground Euthanasia"*); Kelly Green, Note, *Physician-Assisted Suicide and Euthanasia: Safeguarding Against the "Slippery Slope" – the Netherlands Versus the United States*, 13 Ind. Int'l & Comp. L. Rev. 639, 665-71 (2003) (*"Safeguarding Against the Slippery Slope"*). These guidelines were adopted by the Royal Dutch Medical Association in 1984, and codified with little modification in 2002 as the Termination of Life on Request and Assisted Suicide Act ("TLRASA"). *Safeguarding Against the Slippery Slope*, 13 Ind. Int'l & Comp. L. Rev. at 667, 670.[11] In contrast to the ODWDA, the TLRASA does not require that the patient seeking hastened dying be terminally ill, does not require that the patient be mentally competent, and permits euthanasia. For a physician to be exempt from criminal liability, the TLRASA provides that (1) the patient's "suffering" must be "unbearable" "with no prospect of improvement"; (2) the patient's request must be voluntary; and (3) there must be "no reasonable alternative available to the patient." *Id.* at 670.

There is nothing to indicate that the ODWDA, which prohibits euthanasia and imposes far greater limitations on the use of assisted dying, marks the beginning of the descent

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[11] *Termination of Life on Request and Assisted Suicide Act*, Staatsblad, 2002, 165 (available in English at http://www.minbuza.nl/default.asp?CMS_TCP=tcpAsset&id=CA83[illegible]94 94B444D268938017F2330E54E) (last visited July 14, 2005).

on a slippery slope towards the acceptance of euthanasia. Indeed, there is a substantial basis to conclude that terminally ill people with disabilities are *less* vulnerable to abuses, coercion or other undue influences when assisted suicide is authorized by a statute like the ODWDA than when it is prohibited. The ODWDA ensures that only people with the requisite training may assist a terminally ill patient in dying, that the patient is mentally competent to make the decision, and that the decision is made voluntarily and with full information. The fact remains that in jurisdictions that do not permit physician-assisted suicide, including jurisdictions where the practice is outlawed, the practice persists, with no procedural safeguards in place. *See Underground Euthanasia*, 32 J. L. Med. & Ethics at 486 (observing that the empirical evidence that doctors participate in assisted suicide and euthanasia despite prohibitions is beyond serious dispute); Jody B. Gabel, *Release from Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 Fla. St. U. L. Rev. 369, 372-73 (1994); Dick Lehr, *Death & The Doctor's Hand, Increasingly, Secretly, Physicians are Helping the Incurably Ill to Die*, Boston Globe, Apr. 25, 1993 at 1.

The very fact that covert assisted suicide and euthanasia is occurring in prohibitionist states at rates that rival those of the Netherlands,[12] necessarily undermines any slippery slope characterization of legalized assisted dying: "that if [assisted suicide] is legalized, bad things will start to happen. The fact is, harmful, unsafe things are already happening." *Underground Euthanasia*, 32 J. L. Med. & Ethics at 492. Indeed, a nationwide study of 1,902 U.S.

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12 Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 924 (1996); *"Underground Euthanasia"*, 32 J. L. Med. & Ethics at 490.

physicians found that, notwithstanding the current legal restraints, 8 percent of physicians surveyed had participated in assisted suicide or euthanasia, with 3.3 percent admitting that they had written at least "one lethal prescription" and 4.7 percent admitting that they had administered at least one lethal injection. *Underground Euthanasia*, 32 J. L. Med. & Ethics at 486.

Bans on assisted suicide and euthanasia also have not prevented non-physicians from coming to the aid of the dying. One study surveyed 1,139 critical care nurses in the United States, of which 852 (71 percent) practiced exclusively in intensive care units for adults. David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1374-75 (1996). Of the 852 nurses, 141 (17 percent) reported requests from patients or family members for euthanasia or assisted dying; of the 17 percent asked, 129 (16 percent) complied. *Id.* at 1374-79. An additional four percent admitted they had facilitated a terminally ill patient's death by pretending to provide life-sustaining treatment ordered by a physician. *Id.* According to one expert, covert assisted dying and voluntary euthanasia "has spawned a culture of deception," "encompass[ing] the methods used to procure euthanasia drugs, the planning of the death itself, and the disposal of the body and associated paperwork." *Underground Euthanasia*, 32 J. L. Med. & Ethics at 488. In many instances, patients die without having been evaluated for depression or impaired judgment, without adequate palliative care or counseling, and without the assessment of specialists as to the patient's diagnosis, prognosis, and available treatment alternatives. *Id.*

The question thus becomes not whether the option of assisted dying should be available or not, but whether it

should be regulated to prevent the abuses that occur in the absence of regulation.

D. Assisted dying under the ODWDA is consistent with the physician's role in the physician-patient relationship.

Petitioners contend that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer."[13] Petitioners' Brief at 8. This argument, and the Attorney General's Directive that assisting suicide is not a "legitimate medical purpose" within the meaning of the CSA's implementing regulations, 21 C.F.R. § 1306.04, are based on a conception of the physician-patient relationship that minimizes or disregards the many and complex obligations that physicians have towards their patients. *See* Bryan Hilliard, *Evaluating the Dissent in* Oregon v. Ashcroft: *Implications for the Patient-Physician Relationship and the Democratic Process*, 33 J. L. Med. & Ethics 142, 147 (2005) ("*Evaluating the Dissent in* Oregon v. Ashcroft").

The Attorney General's Directive criminalizing physician-assisted suicide conflicts with the traditional ethical obligations of the medical profession to respect patient autonomy, to provide comfort, and to alleviate pain and suffering. *See* American Medical Association Council on Ethical and Judicial Affairs, Code of Medical Ethics, Opinion E-2.20 (2005) ("AMA Code") (instructing that where the physician's duty to "sustain life" conflicts with his or her duty to "relieve suffering," "the preferences of the patient shall prevail"); *id.* ("Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care."). Moreover, physicians have an obligation not to abandon patients "once it is determined that cure is impossible." AMA Code E-2.211 (2005). In its opinion on physician-assisted suicide, the American Medical Association ("AMA") instructs that "[p]atients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication." *Id.*

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[13] This view, which is shared by the American Medical Association, stems from the Hippocratic Oath's provision that "I will give no deadly treatment to anyone if asked . . ." *But see Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 308 (1986) (reasoning that "[s]urely, adherence to the oath would yet admit of a reasonable balancing between the doctor's obligation to alleviate suffering and his obligation to preserve life"). The medical profession has in fact accommodated deviations from the oath in the past, *see id.* (noting that the oath also provides that "I will not give a woman an instrument to produce abortion"), and the AMA has left open the possibility that it will likewise change its position on assisted suicide. *See* AMA Code H-140.966 ¶ (4) (2005) (acknowledging in its statement on euthanasia and assisted suicide that "[i]n certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great," but "more careful examination of the issue is necessary" and that "the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide *at this time*") (emphasis added). Significantly, the British Medical Association ("BMA") recently did exactly that and departed from its longstanding opposition to physician-assisted suicide. Celia Hall, *'Historic' Change as Opposition to Euthanasia Ends*, Daily Telegraph, July 1, 2005 ("*'Historic' Change*"), *available at* 2005 WLNR 10348879; John Carvel & Sarah Boseley, *BMA Drops Opposition to Doctor-Assisted Suicide*, Guardian (UK), July 1, 2005 ("*BMA Drops Opposition*"), *available at* 2005 WLNR 10318566. As of late June 2005, the BMA has officially taken a "neutral position" on the issue, meaning that it would not object to the passage of legislation allowing physician-assisted suicide. *BMA Drops Opposition*, Guardian (UK), July 1, 2005. According to Dr. Evan Harris, the Member of Parliament who urged the BMA to change its policy, whether assisted dying should be permitted "is now a matter for Parliament to decide, and the role of the medical profession is to press for the necessary safeguards, not to oppose an overdue move." *'Historic' Change*, Daily Telegraph, July 1, 2005.

As one commentator has observed, physicians who participate in assisted dying believe that they are adhering to their obligation to aid and comfort their patients. DAVID ORENTLICHER, M.D., MATTERS OF LIFE AND DEATH: MAKING MORAL THEORY WORK IN MEDICAL ETHICS AND THE LAW 42 (2001) ("When a patient and a physician have gone together through a long and arduous battle with disease, and the patient concludes that suicide is now the best option, the physician may not want to abandon the patient and insist that the patient go forward without the physician by her side"). This view reflects the belief shared by proponents and opponents to assisted suicide that the use of controlled substances provides the least painful and most dignified method of hastening one's death. *See Evaluating the Dissent in* Oregon v. Ashcroft, 33 J. L. Med. & Ethics at 142. Indeed, during the period when death is imminent and suffering becomes intolerable, the decision to hasten imminent death is most analogous "to decisions that are generally accepted as proper instances of exercising autonomy over one's own body, instances recognized under the Constitution and the State's own law in which a physician's assistance is accepted as falling within the traditional ethical norm of professional conduct." *See Glucksberg*, 521 U.S. at 779-80 (Souter, J., concurring) (noting that such instances include the administration of heavy dosages of pain medication, even if such unintentionally hastens death, the withdrawal or withholding of life-sustaining medical treatment, and the practice of terminal sedation).

Indeed, this Court implicitly has rejected the type of one-dimensional understanding of the physician-patient relationship advanced by Petitioners. *See Roe v. Wade*, 410 U.S. 113, 153 (1973) (declining to limit the physician's participation to curative measures and recognizing the physician's obligation to provide and the patient's right to

receive counsel and care in the abortion context); *see also Glucksberg*, 521 U.S at 779 (Souter, J., concurring). In his concurring opinion in *Glucksberg*, Justice Souter expressed concern that terminal sedation might be the only option available to terminally ill patients seeking to hasten an end to their suffering. *Glucksberg*, 521 U.S at 779 (Souter, J., concurring). Recognizing that "[t]here can be no stronger claim to a physician's assistance than at the time when death is imminent," *id.* at 781, Justice Souter observed that this Court's abortion cases illustrate a broader view of the physician's role that would encompass assisted dying. *See Glucksberg*, 521 U.S at 779 (Souter, J., concurring). As Justice Souter explained, this Court has recognized that "the good physician is not just a mechanic of the human body whose services have no bearing on a person's moral choices, but one who does more than treat symptoms, one who ministers to the patient." *Glucksberg*, 521 U.S at 779 (Souter, J., concurring) (citing *Roe*, 410 U.S. at 153; *Griswold v. Connecticut*, 381 U.S. 479, 482 (196[illegible])). Refuting the notion that the physician's role is limited to that of "healer," Justice Souter further explained:

> This idea of the physician as serving the whole person is a source of high value traditionally placed on the medical relationship. Its value is surely as apparent here as the abortion cases, for just as the decision about abortion is not directed to correcting some pathology, so the decision in which a dying patient seeks help is not so limited. The patients here sought not only an end to pain (which they might have had although at the price of stupor) but an end to their short remaining lives with a dignity they believed would be denied them by powerful pain medication, as well as by their consciousness of

dependency and helplessness as they approached death.[14]

Regardless of whether one agrees with the Attorney General's view of the physician-patient relationship, the CSA does not authorize him to impose his definition of the physician's role upon states, physicians and patients through administrative fiat. Amici acknowledge that the question whether physician-assisted suicide is part of the legitimate practice of medicine is the subject of debate, but the Attorney General impermissibly seeks to delineate the contours of the physician-patient relationship in a manner that is contrary to congressional intent and that disregards the multiple role obligations of the medical profession.

CONCLUSION

For decades, individuals with disabilities have had to defend their right to make choices and maintain control over all aspects of their lives. Amici believe that this right to autonomy and self-determination applies with no less force to the most uniquely personal, moral and religious choice of all -- the choice of whether to hasten impending death from a terminal condition. Most importantly, it is a choice that Oregon in its considered policy determination has empowered all capable, terminally ill adults, including those with disabilities, to make for themselves. This policy determination cannot be superseded by the unilateral action of a federal agency where, as here, Congress did not clearly convey its intent to disrupt the delicate federal-state balance. For all the foregoing reasons, Amici respectfully submit that the decision of the Court of Appeals should be affirmed.

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[14] *Glucksberg*, 521 U.S. at 779 (Souter, J., concurring).

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